

MDR Tracking Number: M5-04-2170-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution - General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. The dispute was received on 03-15-03.

The Medical Review Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. The IRO agrees with the previous determination that the work hardening program, functional capacity exam and physical performance test were not medically necessary. Therefore, the requestor is not entitled to reimbursement of the IRO fee.

Based on review of the disputed issues within the request, the Medical Review Division has determined that fees were the only fees involved in the medical dispute to be resolved. As the services listed above were not found to be medically necessary, reimbursement for dates of service from 08-18-03 through 09-26-03 is denied and the Medical Review Division declines to issue an Order in this dispute.

This Findings and Decision is hereby issued this 6th day of July 2004.

Debra L. Hewitt
Medical Dispute Resolution Officer
Medical Review Division
DLH/dlh

IRO Certificate #4599

NOTICE OF INDEPENDENT REVIEW DECISION

June 30, 2004

Re: IRO Case # M5-04-2170-01 amended 7/2/04

Texas Worker's Compensation Commission:

___ has been certified as an independent review organization (IRO) and has been authorized to perform independent reviews of medical necessity for the Texas Worker's Compensation Commission (TWCC). Texas HB. 2600, Rule 133.308 effective January 1, 2002, allows a claimant or provider who has received an adverse medical necessity determination from a carrier's internal process, to request an independent review by an IRO.

In accordance with the requirement that TWCC assign cases to certified IROs, TWCC assigned this case to ____ for an independent review. ____ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. For that purpose, ____ received relevant medical records, any documents obtained from parties in making the adverse determination, and any other documents and/or written information submitted in support of the appeal.

The case was reviewed by a physician who is Board Certified in Physical Medicine and Rehabilitation, and who has met the requirements for TWCC Approved Doctor List or has been approved as an exception to the Approved Doctor List. He or she has signed a certification statement attesting that no known conflicts of interest exist between him or her and any of the treating physicians or providers, or any of the physicians or providers who reviewed the case for a determination prior to referral to ____ for independent review. In addition, the certification statement further attests that the review was performed without bias for or against the carrier, medical provider, or any other party to this case.

The determination of the ____ reviewer who reviewed this case, based on the medical records provided, is as follows:

Medical Information Reviewed

1. Table of disputed service
2. Explanation of benefits
3. Peer review 10/2/03
4. D.O. clinical notes
5. M.D. evaluation 5/16/03
6. DDE 9/24/03
7. MRI lumbar spine report 5/23/03
8. MRI thoracic spine report 6/24/03
9. Initial consultation note 10/2/03
10. Outpatient psychotherapy progress note 10/22/03, 10/29/03
11. PPE 8/11/03, 9/11/03
12. FAE 8/29/03, 9/23/03
13. Work hardening progress notes

History

The patient is a 50-year-old female who in ____ was retrieving a tray in a walk-in freezer when she tripped and fell on the floor, landing on her upper and mid back. She presented on 4/21/03 with severe pain in her upper and lower back and right shoulder. She was started on physical therapy, and it was continued on a daily basis. The patient was evaluated on 5/16/03, and injections and continued therapy were recommended. A physical performance evaluation on 8/11/03 demonstrated

the patient's ability to function only at a sedentary lifting category. ROM, strength and conditioning deficits were also reported. A psychological evaluation and work hardening program were recommended.

Requested Service(s)

Work hardening program, functional capacity exams, physical performance test
8/18/03 – 9/26/03

Decision

I agree with the carrier's decision to deny the requested services.

Rationale

The patient was treated very extensively with daily physical therapy for about four months. She was kept off work the entire time, and no evidence was provided for this review that she attempted to return to work with restrictions. The only objective findings noted on the report of the 5/16/03 evaluation were tenderness over the midline, thoracolumbar area, lower lumbar area and right greater trochanter. Electrodiagnostic testing performed, as part of a designated doctor evaluation was normal. A functional capacity evaluation On 8/11/03 reported the patient's ability to occasionally lift 15 lbs. And frequently lift 10 lbs. The patient's reported work requirement was 20 lbs. and 10 lbs. respectively. There was no job description from the employer in the documents provided for review. The patient underwent more than adequate, even exhaustive, physical therapy and should have been continued on a home exercise program and return to work with restrictions, with a gradual return to regular job duties.

This medical necessity decision by an Independent Review Organization is deemed to be a Commission decision and order.